

PARTNERS IN FAMILY PRACTICE, LTD.
4048 Dressler Rd., N.W., Suite 203
Canton, Ohio 44718

Legal Authorizations

MINOR CONSENT

I/We, the undersigned parent(s) or legal guardian of _____ a minor, do hereby authorize and consent to any medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff at Partners in Family Practice, Ltd. under the provisions of the Medicine Practice Act. It is understood that this authorization is given in advance of any specific diagnosis and/or treatment being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his or her best judgment may deem advisable.

HIPAA ACKNOWLEDGEMENT

I, _____, the undersigned Patient or the parent and/or legal guardian of the patient acknowledge that I have received a copy of Partners in Family Practice's Notice of Privacy Practices. **Our practice leaves normal results on your answering machine. If you would prefer not to receive normal results on your answering machine please notify us.**

I **DO NOT** authorize the office to contact me the following manner:

- _____ DO NOT telephone home and leave message with detailed information
- _____ DO NOT telephone home and leave message with a call back number only
- _____ DO NOT telephone work and leave message with a call back number only
- _____ DO NOT mail to my home address

CANCELLATION POLICY

Due to the very busy schedule of Dr. Tammy Eisentrout, Dr. Gina Volpe, Christine Echols C.N.P., and Gina Jones C.N.P., we have found the need to develop a policy for cancellations and missed appointments is as follows:

All appointments must be cancelled or rescheduled 24 hours in advanced. If you fail to give appropriate notice on 3 occasions then treatment at this office will be terminated. It will be your responsibility to find another private physician or contact your insurance carrier for further treatment.

MISSED APPOINTMENTS

The fee for missed appointments not cancelled within a 24 hour period, will be \$25.00. This fee must be paid prior to the next appointment. There will also be a \$10.00 fee to call in medications if it is due to a missed appointment or cancellation that was not done within the 24 hour period. This will have to be paid prior to seeing the doctor at the next appointment time.

FINANCIAL POLICY

We ask for co-payments and deductibles at the time of service. For all self pays, we do ask for \$50 down payment at the time of service.

With the proper information, we will prepare and file your insurance claims as a service to you free of charge. In some cases, you may need to file your own claims. We will assist you by providing you with an itemized statement that you can attach to your form and submit.

Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We CANNOT guarantee payment of your claims, and our office will NOT accept responsibility of negotiating claims with your insurance companies or other persons. The Patient is responsible for payment of his/her medical care, regardless of the status of the claim. If your insurance company pays only a portion of your bill or rejects the claim, any contact or explanation should be made to you, the policy holder. Reduction or Rejection of your claim by your insurance company does not relieve your financial obligation that you have incurred with our office. If necessary we will lend assistance when needed to help process your rejected claims.

*There is a \$20 charge to fill out disability forms with a 48 hour notice.

*There is a \$35 charge for a written NSF check.

*We reserve the right to charge for transfer of medical records

By signing below I agree that all of the above is true to the best of my knowledge. I agree to give Partners in Family Practice, Ltd. Permission to bill my insurance company on my behalf. I agree that ultimately I am responsible for all incurred costs not covered by my insurance company and it is my responsibility to know the terms of coverage for my insurance plan.

Patient Signature and/or Parent(s) or Legal Guardian of Patient

Date